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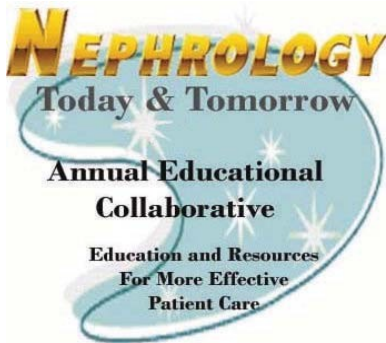


Find out what's *new*, what's *due* & what's *upcoming*...



Please **POST** for all staff and personnel to read.

June 2010



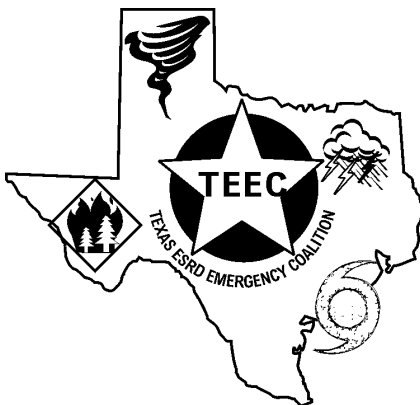
Nephrology Today & Tomorrow 2010

We **CAN** Do Better

June 25-26, 2010

Dallas, Texas

Registration is now open - go to [www.esrdnetwork.org](http://www.esrdnetwork.org)



Upcoming meeting in **YOUR** area!

Mark you calendar now to attend!

- 6/ 26/10 Dallas after Network Annual Meeting
- 7/27/10 Big Sandy
- 8/26/10 Bryan/College Station
- 9/23 Austin
- 10/28/10 Corpus Christi



## From the Patient Services Department:

The Network had added some great resources to our website recently. There are three new webinars. (1) Patient Safety-Better Outcomes (2) The Patient Whisperer (3) IVD-Proactive Prevention

We also have the Involuntary Discharge Checklist and Memo which provides your facility with all required documentation in the event of C(6) Involuntary Discharge. Please contact us if a patient is considered and “at risk” for involuntary discharge.

Please feel free to contact the Patient Services Coordinator, John Q. Gowan, LMSW @ [jgowan@nw14.esrd.net](mailto:jgowan@nw14.esrd.net) or 469-916-3808.

## From the Information Management (Data) Department

### **Patient Self-reporting of Ethnicity and Race on the OMB 2728 Form**

Ethnicity and race shall be “self-reported” by the patient to be in conformance with current OMB standards. “Self-reported” is defined as the patient’s verbal or written confirmation of ethnicity and race. It is important to note that the current instructions on CMS Form 2728 do not specify that the information on ethnicity and race must be self-reported, and therefore it is likely that in some cases the information is actually “provider-reported.”

CMS instructs the ESRD Networks to educate the ESRD Medicare Provider community on how to correctly document patient ethnicity and race. Whenever possible, providers must document the patient’s self-reported ethnicity (field 8) and race (field 10) on the OMB 2728 Form. In the event that a patient or patient’s family member is unable to self-report their ethnicity and/or race, providers are to record this information on behalf of the patient, and acknowledge the absence of the patient’s self-reported ethnicity and race in the remarks area (field 53) by noting that “fields 8-10” were reported by \_\_\_\_\_.

With the roll-out of the CROWNWeb national release, the ESRD provider community will be required to document whether ethnicity and/or race was self-reported by the patient or by a patient’s family member and if the patient chose not to report their ethnicity and/or race.



### **Missing Forms**

The Missing Forms Report is a monthly notice that Network 14 mails to any facilities which have 2728 or 2746 forms that have not been received. The report picks up this data by displaying patient records in our database that have PAR events (i.e. new ESRD patient, death, restart dialysis) which require forms per CMS for entitlement and/or registration purposes.

If you are getting a Missing Forms Report indicating that Network 14 has not received a form and you have mailed it, you should use this checklist prior to calling NW 14:



### Missing Forms Checklist

- \_\_\_ Missing Forms Report compared with PAR and 2728 form to verify all data matches (SSN, DOB, name spelling)
- \_\_\_ 2728 form was submitted to NW14 **via MAIL** with either a triplicate copy (Green, blue, white) or the **Attending Physician's BLUE INK SIGNATURE**
- \_\_\_ The address that the 2728 or 2746 was mailed to is correct: 4040 McEwen, Suite 350, Dallas, TX 75244
- \_\_\_ The patient signature is present on the 2728 form (unless the pt. is deceased)

If you determine that you have met all of these checklist elements, contact Jennie Conley (469)916-3805 or Casey Contreras (469)916-3809 and we will be happy to assist you.

Thanks for your hard work and support!

## QI Corner

### Bicarbonate Concentrate mixing



Surveyor

Sighting

Deficiencies have been cited frequently related to improper mixing of Bicarbonate Concentrate. Please be sure to review the manufacturer's recommendations when mixing concentrates:

➤ **AAMI Rationale for the Development and Provision of This Recommended Practice**

**A.5.4.4.3 Bicarbonate concentrate mixing systems**

Over agitation or mixing of bicarbonate concentrate may result in loss of CO<sub>2</sub> from the solution. Loss of CO<sub>2</sub> results in an increase in pH and favors the formation of carbonate that can lead to precipitation of calcium and magnesium carbonate in the fluid pathways of the dialysis machine following dialysate proportioning.

➤ **Additional Guidance:**

There must be a system to prevent over mixing of bicarbonate. This could include a timer integrated into the mixing system for automatic cut-off, or a policy to require staff to monitor the mixer and cut it off immediately when the time period for mixing is completed. Use of over mixed bicarbonate concentrate can result in a low calcium level in the dialysate and a concomitant drop in patients' serum calcium levels.

For more information please contact Sherry Green, Quality/Patient Services Nurse at [sgreen@nw14.esrd.net](mailto:sgreen@nw14.esrd.net).

## QAPI



### Surveyor

### Sighting

- 
- The Texas surveyors are also reporting that there is high number of deficiencies being cited for the facility QAPI minutes.
- The area most cited is that facilities collect their data monthly but do not “Continuously monitor”.
- Continuous monitoring requires that outcome data, achievement of treatment goals, adverse events, infections, falls, errors, etc. be monitored as this data is available or these events occur.
- Tracking and trending, analysis of root causes, development of improvement plans, implementation of those plans, evaluation of the success of the plan, and revision of the plan must occur as indicated.
- Once improvement is made, the facility must have a mechanism to ensure that improvement is sustained. This could include practice audits, review of records, or repeat patient satisfaction surveys, etc.
- **The important aspects of the QAPI program are appropriately monitoring data/information; prioritizing areas for improvement; determining potential root causes; developing, implementing, evaluating, and revising plans that result in improvements in care.**
- The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility’s organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.
- Remember, you need to collect the data – but that is only the beginning. Then you need to Track, Trend, Analyze, and Act on the information you have (and maintain a clear documentation trail of the steps you have taken).

For more information please contact Sherry Green, Quality/Patient Services Nurse at [sgreen@nw14.esrd.net](mailto:sgreen@nw14.esrd.net).

## 2010 Quality of Care Reports

- ❖ By May 31, 2010, the following items will be available on our website at: [www.esrdnetwork.org](http://www.esrdnetwork.org) – Professionals – Quality Improvement with the outcomes of the 2010 Quality of Care Data Collection Results (4<sup>th</sup> quarter 2009 data):
  - Adult
    - Facility Run Charts for Hemodialysis and Peritoneal Dialysis
    - Facility Report Cards for Hemodialysis and Peritoneal Dialysis
    - Quality of Care Indicator Results for Hemodialysis and Peritoneal Dialysis
  - Pediatric (\*NEW\*)
    - Facility Run Charts for Hemodialysis and Peritoneal Dialysis
    - Facility Report Cards for Hemodialysis and Peritoneal Dialysis

- Quality of Care Indicator Results for Hemodialysis and Peritoneal Dialysis
- ❖ For those facilities that do not meet the MRB established Quality of Care cut-points, the package will also contain a letter identifying the area that *potentially* does not meet the cut-point and instructions for actions required by the facility. Please be sure to review your packages closely and follow instructions provided. The facility will be given an opportunity to submit to the Network current indicator outcomes and if those indicators meet the MRB Cut-Point, the Network will remove them from the Potential Quality of Care Concern List.
- ❖ This is the first year that the Network is identifying *Potential* Pediatric Quality of Care Concerns.
- ❖ The Network will also be analyzing the data to determine those facilities with outstanding performance over the past 2 years, and certificates acknowledging Benchmark and Recognized Facilities will be sent to those that meet the selection criteria.
  - Facilities in the top 10% for the last 2 years receive a Benchmark Certificate
  - Facilities in the top 10% for the current year receive a Recognized Certificate
  - Exclusions include:
    - Facilities that have had a Texas DSHS survey that resulted in a referral to the MRB with a Corrective Action Plan (CAP) of a Level II or III within the last 2 years.
    - Use of post-dialysis blood draws method to report serum albumin outcomes.
    - One or more current year quality core indicators met quality of care concern cut-points.

For more information please contact Angie Wieler, QI Coordinator, at [awieler@nw14.esrd.net](mailto:awieler@nw14.esrd.net).

## Phosphorus Module Update

- ❖ A **BIG TEXAS SIZED “Thank You”** to all the facilities that submitted a poster for the Phosphorus Poster Contest! We received **nearly 50** posters that have been reviewed by the Patient Advisory Committee members. We are in the process of notifying the winners. The creative and innovative strategies used for education is tremendous. The amazing artistic talents of the facility team members deserves special acknowledgement too – you did a great job creating those posters!
- ❖ The Grand Prize Winner will receive a plaque recognizing their creative talent and **2 free admissions** (for 1 Dietitian & 1 Patient Care Technician) to the Network Annual Meeting **“Nephrology Today and Tomorrow 2010: We Can Do Better!”** on June 25 & 26, 2010. The First Runner Up will also receive a plaque that recognizes their artistry and efforts.

For more information please contact Carolyn Atkins, QI Nurse, at [catkins@nw14.esrd.net](mailto:catkins@nw14.esrd.net)

## Fistula First in Texas

- ❖ We have just received word from CMS that the March 2010 Fistula First Dashboard Data will not be released until mid-June 2010. Due to the delay in obtaining this data the Fistula First Mail out scheduled for the end of May 2010 will be delayed until early July 2010. We apologize for any inconvenience, and will provide the data charts to all facilities as soon as we have received and prepared the components for the mail out.

For questions, please contact Angie Wieler, QI Coordinator, at [awieler@nw14.esrd.net](mailto:awieler@nw14.esrd.net).



# Kidney Health Care Program Access Surgery Quick Sheet

## **Benefit Explanation**

Access surgery typically occurs **before** the patient with End-Stage Renal Disease (ESRD) is approved for Medicare or Kidney Health Care (KHC). However, a KHC client's medical benefits for access surgery are retroactive and can be paid if the surgery happens:

- 180 days or less prior to the client's KHC effective date, **and**
- on or after the date the client became a Texas resident according to KHC's records.

Please note that KHC clients who can get Medicare or Medicaid **cannot** get medical benefits through KHC.

## **Filing Deadlines**

Existing KHC providers can file claims for access surgery as soon as the patient finds out that he or she can get the KHC medical benefit. KHC **must** receive the claims by the later of:

- 95 days from the last day of the month in which services were provided; **or**
- 60 days from the date on the KHC notice of eligibility for newly approved clients.

Newly approved KHC providers must ensure that KHC receives their claims:

- 60 days from the date on the agreement approval letter, **and**
- not later than 180 days from the date of service.

For more information about Kidney Health Care benefits, please call: 1-800-222-3986, fax: 512-458-7162, e-mail: [kidneyet@dshs.state.tx.us](mailto:kidneyet@dshs.state.tx.us) or write to:

Kidney Health Care  
Purchased Health Services Unit, MC 1938  
Texas Department of State Health Services  
P O Box 149347  
Austin, TX 78714-9347

## **Benefits and Rates**

KHC has specific benefits it can pay contracted providers for services related to access surgery, including re-access and de-clotting procedure codes. The maximum rates for each provider type appear in the tables below and on page 2.

<b>Provider</b>	<b>Rate</b>
Ambulatory Surgical Center	Billed amount, up to a maximum of \$2,050.
Hospital	Billed amount x RCC rate on file, up to a maximum of \$4,100.
Surgeon	See page 2 for the list of allowable procedures and rates. Rates vary depending on Medicaid rates at the time the procedure was added to the list.
Assistant Surgeon	25% of surgeon's rate.
Anesthesiologist or CRNA	\$290.00 flat rate.

## Allowable KHC Access Surgery Procedure Codes and Rates

CPT Code	Rate	CPT Code	Rate	CPT Code	Rate
*532	\$290.00	36565	\$259.47	36819	\$635.81
*840	\$290.00	36566	\$278.38	36820	\$632.66
*1840	\$290.00	36568	\$162.40	36821	\$515.80
*1844	\$290.00	36569	\$75.61	36825	\$686.50
34471	\$379.13	36570	\$233.70	36830	\$652.12
34490	\$440.50	36571	\$235.99	36831	\$353.70
35188	\$655.44	36575	\$225.11	36832	\$582.82
35190	\$697.72	36576	\$284.68	36833	\$510.65
35321	\$768.36	36578	\$225.11	36834	\$537.85
35460	\$285.85	36580	\$162.40	36838	\$944.25
35475	\$448.96	36581	\$225.11	36860	\$151.22
35476	\$285.85	36582	\$284.68	36861	\$254.04
35761	\$330.03	36583	\$225.11	36870	\$1,037.62
35860	\$346.83	36584	\$75.61	37201	\$404.10
35903	\$500.34	36585	\$284.68	37205	\$406.69
36005	\$42.92	36589	\$131.74	37206	\$203.06
36010	\$146.07	36590	\$161.53	37207	\$406.69
36145	\$174.70	36595	\$675.33	37208	\$203.06
36217	\$317.90	36596	\$148.64	37607	\$289.83
36555	\$162.40	36597	\$105.68	49420	\$120.86
36556	\$93.08	36598	\$40.10	49421	\$296.71
36557	\$226.82	36800	\$148.64	49422	\$309.59
36558	\$226.54	36810	\$288.12	49425	\$617.76
36560	\$267.78	36815	\$199.66	49426	\$461.39
36561	\$261.19	36818	\$556.47	49428	\$305.58
36563	\$321.34			49429	\$327.06

**Rates effective June 1, 2008, and current as of May 1, 2010.**

\*For anesthesiology services



# June 2010

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8 <i>May PARs due</i>	9	10 <i>May 2010 Non-LDO FF Data Due</i>	11	12
13	14	15	16	17	18 <i>May missing form due</i>  <i>Quality of Care Fax back due</i>	19
20	21	22	23	24	25	26
					Nephrology Today & Tomorrow 2010  Network Annual Meeting	
27	28	29	30 <i>June missing forms mail to facilities</i>  Quality of Care data submission deadline For potential QOC Concern facilities			

2728 Forms that are not triplicate copies **MUST BE SIGNED IN BLUE INK BY THE PHYSICIAN.** If the Network receives any form (other than a triplicate) without the original BLUE INK signature, it **will not** be